Mark J. Powers, MD
Joseph M. Wierzbicki, MD
Jason P. Williams, DO
Edward J. Southard, MD

Robert I. Forster, MD
Robert A. Sellards, MD
Rachel Rouse, APRN

APPT DATE: **ACCT#:**

PATIENT INFORMATION

Last Name:	First:	Middle:	*Preferred Name	Mr. ☐Mrs. Miss ☐Ms. ☐ Dr.	Marital Status: (circle one) Single / Married / Divorced / Sep Widow / Significant Other

Date of Birth:	Social Security #:	Race: ☐ Decline to answer	Preferred Language:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Mailing Address:			Home Phone #: ☐ Primary
City:	State:	Zip Code:	Cell Phone#: ☐ Primary
Alternate Address: (Please provide dates)			Email Address: (patient portal)
Employer:	Occupation:		Work Phone #:

Referred by (please check box): ☐ Dr.				☐ Insurance Plan	Hospital
Urgent Care Center	☐ Family	☐ Friend	☐ Yellow Pages	Website	Other

EMERGENCY CONTACT

Name:	Relationship to Patient:	Phone#:

INSURANCE INFORMATION

Primary Insurance: ______________________ Secondary Insurance: ______________________

Reason for Visit: ______________________

Is your injury work or auto related? ☐Yes ☐No Do you have an attorney for this issue? ☐ Yes No

Accident/Injury Date: ______________________

☐ **Please check here if the patient is the primary insurance holder. If not, complete the section below.**

Policy Holders Name:	Date of Birth:	Address (if different):	Home Phone #:
Is this person a patient here? ☐Yes ☐No			Social Security #:
Employer:	Employer address:		Work Phone #:

Patient's relationship to primary insurance holder: Spouse ☐ Child Other

FINANCIAL AGREEMENT

Prior to your appointment please check your insurance information so you will informed about referrals, co-payments, and any deductible required at the time of visit

CO-PAYMENTS AND BALANCES:

Co-payments are due at the time of check in, unless prior arrangements have been made with our Billing Department. This arrangement is part of your contract with your insurance company. Please note that our physicians are specialists and higher co-pays may apply. If you cannot pay your co-payment, you may have to reschedule your appointment. Unpaid deductibles, co-insurance percentages, non-covered services and/or other outstanding balances are due upon check-out.

FOR UNINSURED PATIENTS:

A deposit of $350 is due at the time of check in, unless prior arrangements have been made with our Billing Department. Payment must be in the form of cash, Visa, MasterCard, Discover or money order. Personal checks are not accepted. All balances will be collected at time of check-out. If applicable, same-day refunds will be made

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize release of information necessary to file a claim with my insurance company, and I assign benefits, otherwise payable to me, to the doctor or group indicated on the claim. I understand that if my insurance carrier has not responded to a claim within 90 days, Florida Orthopaedic Specialists reserves the right to formally transfer all associated liability for the claim to the patient/guarantor. I understand that I am financially responsible for any balance not covered by insurance. A copy of my signature is as valid as the original.

GUARANTEE OF ACCOUNT:

This is to certify that I, the undersigned, promise to be responsible for the payment of all charges for services rendered to the named patient. I further understand that all applicable charges are due at the time services rendered excluding charges that my insurance company is contractually responsible for payment. I understand that patient accounts that are not paid promptly are subject to third party collections and/or legal procedures. If this account should require collection procedures, I, the undersigned, will be responsible for any charges associated with the collection process, including reasonable attorney's fees. We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and my affect timely payment of your account. If such extreme cases do occur, please contact our Billing department promptly for assistance in the management of your account.

Note to Medicaid patients: Florida Orthopaedic Specialists nor its physicians participate in the Medicaid program. If you are insured through the traditional Medicaid program or Medipass, the person who signs below will be responsible for all charges for services rendered. The undersigned will incur a financial obligation. Your signature below also represents authorization for treatment of the patients receiving services.

Note to Out of Network Patients: If Florida Orthopaedic Specialists and/or its physicians are not participating providers with your plan, we will expect payment in full at the time of service. We will file your claim to your insurance company on your behalf. Florida Orthopaedics Specialists does NOT participate with Medicare Advantage Plans.

OFFICE POLICIES

FORM FEES:

If you require a particular form (ex: FMLA, Disability, AFLAC) to be completed by our physicians, there is a fee of $25 per form. This fee is to be paid prior to completion. Please allow adequate time, as every physician may not be in the office on a daily basis.

MEDICAL RECORD REQUESTS:

If copies of medical records are needed there will be a fee of $1.00/page for the first 25 pages, then it is $0.25/page from page 26 forward. If you need x-ray film copies for any reason, there is charge of $10/sheet. We are now able to provide our patients with copies of MRI's in the form of a disc at $10/CD (pick-up only). If you require they be mailed, there is an additional $3 postage fee. If you still need actual MRI film copies, they are available for $10/sheet. Please allow 48-72 hours for copies of records/films/CDs. Please be advised the original films must remain in our possession, as required by law, as they are a part of your permanent medical record.

PRESCRIPTION REFILL REQUESTS:

Prescription refill requests must be made Monday through Friday, 9:00 a.m. – 4:00 p.m. Please note that requests made after 4 p.m. will not be processed until the following business day. Please allow 48-72 hours to process your refill request, as every physician may not be in the office on a daily basis.

RETURNED CHECK FEE:

I understand any returned check from the bank will result in an additional $25.00 charge that will appear on my account.

Patient Signature	Date	Parent/Guardian Signature (If Minor)	Office Initials

MEDICARE LIFETIME AUTHORIZATION:

I hereby authorize release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to the party who accepts assignment.

Patient Signature	Date	Parent/Guardian Signature (If Minor)	Office Initials

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 772-335-4770.

Please sign this "Acknowledgment" form. Please note that by signing this Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices (HIPAA Omnibus Notice of Privacy Practices).

Acknowledgment of Receipt of the Notice of Privacy Practices (HIPAA Omnibus Notice of Privacy Practices)

______________________________ ______________

Signature of patient or representative Date

May we leave private medical information in a voicemail? Yes ☐ No ☐

If yes, at what telephone number? ______________________________

RELEASE OF INFORMATION

I authorize Florida Orthopaedic Specialists to disclose my protected health information **(medical records, prescriptions, appointment information, etc.)** to the following:
(For example: Primary Care Physician, Spouse, Family Member, etc.)

Signature of Patient______________________________

______________________ ______________________

Name (PRINT) Relationship

______________________ ______________________

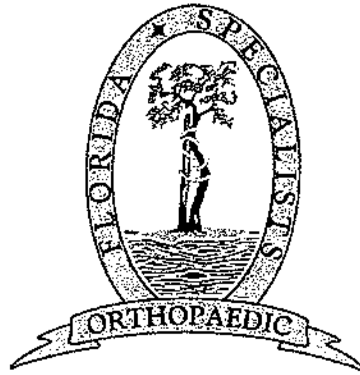
Name (PRINT) Relationship

______________________ ______________________

Name (PRINT) Relationship

☐ Check the box ONLY if you decline to release your protected health information to anyone.

Date: ________________



Account #: ________________

We are utilizing an automated phone system to confirm *ALL* of our patient's appointments.

Patient Name: ____

Please indicate below your preferred method of contact. We are requesting a Primary phone number and a Secondary phone number. Please circle which phone number is Primary and which is Secondary.

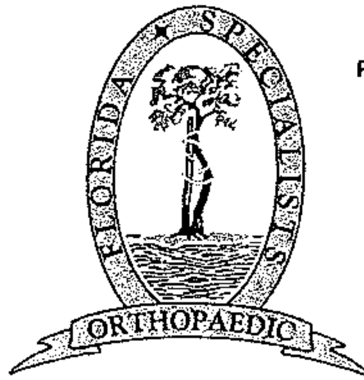
Home Phone Number: ____________________	**Primary**	**Secondary**
Cell Phone: ____________________	**Primary**	**Secondary**

Disclosure: Usual cell phone rates may apply. If you DO NOT want to be contacted on your Cell Phone, please indicate home phone only.

Thank you,

Florida Orthopaedic Specialists

Date: ____________



Patient ID #: ______________

Patient Portal Invite Request

The Patient Portal is an online tool to easily and quickly view your upcoming appointments, request prescriptions refills, review your health information and communicate with our office from the convenience of your home or mobile device.

Accept

First Name: ____________________ Last Name: ___________________________

Email Address: ____

Once you receive the registration link from MyHealthRecord.com, answer the data verification questions, and login.

Decline

☐ **NO Thanks,** I choose not to share my email or I do not have an email.

If you **DO NOT** want to participate in the Patient Portal, please provide us with your name and signature. Thank you.

First Name: ____________________ Last Name: ___________________________

Signature: _______________________________ Date: ___________________

API (*Application Programming Interface*): This allows patients to access their personal health information using third-party applications that the patient chooses.
If you decline at this time, you can accept access later.

Accept: ________ **Decline:** ________

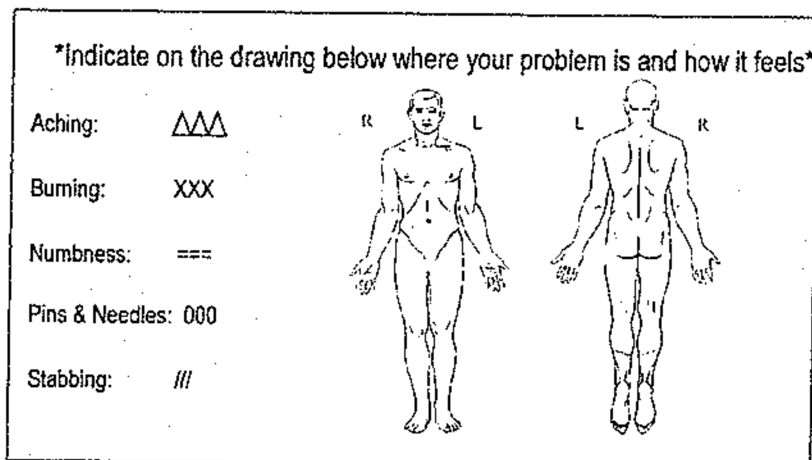
HEALTH HISTORY QUESTIONNAIRE

DATE: ____________________ ACCT #: ________________

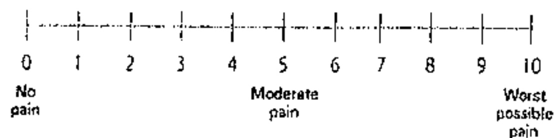
Patient Name:	Age:	Sex: ☐ M ☐ F
Primary Care Physician:	Local Pharmacy & Location:	

Reason for visit: ____

Is your injury the result of an auto or work comp accident? ☐ **Yes** ☐ **No**
If yes, please explain: ____
(Type, date of accident, where it occurred, briefly explain how the injury happened)



Circle a number from 0 to 10 that best describes your pain level:



How long have you had this problem?

_______ **Days** _______ **Weeks**
_______ **Months** _______ **Years**

Are you currently or have recently seen a Pain Management Physician, If so who? ____________________

What increases your pain? ____

What relieves your pain? ____

Have you received treatment or been to the ER or Urgent Care for this issue? Where/When ____________________

What treatments did you receive? (Injections, medications, etc.) ____________________

Did they conduct Imaging (X-ray, MRI, CT Etc.)? ____________________

Have you previously completed Physical Therapy for this concern? ____________________

SURGICAL HISTORY

List previous treatments, Orthopedic surgeries and emergency hospitalizations in the *last* year.
(Include orthopedic surgeries i.e. Hip, Knee, Shoulder, etc.)

When:	What body part:	Why:	Surgeon Name:

PATIENT MEDICAL HISTORY

Check all that apply:

☐ NONE APPLY	☐ Coronary Artery Disease	☐ Kidney Disease	☐ Alzheimer's/Dementia
☐ Asthma	☐ Diabetes I, II	☐ Epilepsy/Seizures	☐ Stroke/TIA
☐ Anxiety	☐ Heart Disease	☐ Peripheral Artery Disease	☐ Coronary Artery Bypass Grafting
☐ Auto Implantable Cardo-Defib ☐ Pacemaker	☐ Hepatitis	☐ Sleep Disorders	☐ Bleeding Disorder
☐ Atrial Fibrillation	☐ High Blood Pressure	☐ Chronic Pain	☐ Cancer, Specify Below:
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Phlebitis	☐ Chronic Anticoagulation/Blood Thinners
☐ COPD	☐ HIV/AIDS	☐ Thyroid Disease	☐ Arthritis/Rheumatoid Arthritis
☐ Tuberculosis	☐ Other	☐ Other	☐ Other

FAMILY MEDICAL HISTORY:

Have any direct relatives had any of the following? If yes, please specify.

(Mother, Father, Sister, Brother, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather, Aunt or Uncle)

☐ NO KNOWN FAMILY HISTORY	☐ Cancer ______	☐ High Blood Pressure ______
☐ Arthritis ______	☐ Diabetes______	☐ Stroke ______
☐ Blood Disorder ______	☐ Heart Attack ______	☐ Other ______

SOCIAL HISTORY

Alcohol Use: ☐ None ☐ Socially ☐ Frequently ☐ Daily Drinks/wk.______ Type: ______	**Work Status:** ☐ Working ☐ Not working ☐ Disabled ☐ Retired ☐ Student	**Current/most recent occupation:**

Do you use any tobacco products?

- ☐ Never — Type of tobacco: ______
- ☐ Former — Amount used: ______
- ☐ Current some days — Age Started: ______
- ☐ Current every day — Age Stopped: ______

Do you currently use any other Nicotine products? ______

Are you currently using any illicit/recreational drugs? **Yes** **No**

If so, which and how often: ______

Highest Level of Completed Education

- ☐ Some High School
- ☐ High School Graduate
- ☐ Some College
- ☐ College Graduate
- ☐ Master's Degree
- ☐ Doctoral Degree

☐ **Right handed** ☐ **Left handed**	**Number of children:** ______	**Height:** ______ **Weight:** ______ **Blood Pressure:** ______(staff only)

List any hobbies that may be affected by your current injury or problem: ______

Rate your current health: ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

ALLERGIES/ADVERSE REACTIONS TO MEDICATION	
Name of Medication	Reaction

☐ I have no know allergies or adverse reactions to any medications
☐ I have a LATEX allergy

CURRENT MEDICATIONS (Include OTC supplements and vitamins!)			
Name of Drug	Dosage (mg, mcg)	Frequency	Date Started

☐ I am not on currently taking any medications, supplements, or vitamins

14 POINT REVIEW OF SYSTEMS Check all that apply:			
☐ NONE APPLY	**General Constitutional** ☐ Fever ☐ Chills ☐ Night Sweats	**Eyes, Vision** ☐ Visual Changes ☐ Double Vision	**Ears, Nose, Throat** ☐ Hearing Loss ☐ Difficulty Swallowing
Allergic/Immunologic ☐ Allergic Reactions ☐ Recurrent Infections	**Respiratory** ☐ Cough ☐ Shortness of breath	**Hematologic/Lymphatic** ☐ Abnormal Bleeding ☐ Bruise Easily	**Psychiatric** ☐ Anxiety ☐ Depression
Musculoskeletal ☐ Joint Pain or Swelling ☐ Restricted Motion ☐ Musculoskeletal Pain	**Skin, Integumentary** ☐ Rashes ☐ Open Wounds ☐ Abnormal Moles	**Heart, Cardiovascular** ☐ Chest pain ☐ Irregular Heartbeat ☐ Palpitations	**Genitourinary** ☐ Frequent Urination ☐ Painful Urination ☐ Incomplete Urination
Endocrine ☐ Heat/Cold Intolerance ☐ Excessive Thirst ☐ Unexplained Weight Loss ☐ Unexplained Weight Gain	**Gastrointestinal** ☐ Abdominal Pain ☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Bloody Stool	**Neurological** ☐ Numbness or Tingling ☐ Sensation Loss ☐ Gait/Balance Problems ☐ Unexplained Weakness ☐ Headaches	☐ **Other**

PATIENT SIGNATURE (or representative): ____________________________

Thank you for taking the time to fill out this questionnaire. The information you present is vital to providing you with optimum and efficient care. Please ask if you need assistance in filling out this form.

HIPAA Omnibus Notice of Privacy Practices

Revised 2021

Effective April/14/2003

Florida Orthopaedic Specialists

9077 South US-1
Port St. Lucie, FL 34952

1151 SE Indian Street
Stuart, FL 34997

Phone: 772-335-4770

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- Complaints

  You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Anne Fulford — **772-335-4770**

HIPAA Compliance Officer — **Phone**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will never share any substance abuse treatment records without your written permission.

CHANGES TO THE TERMS OF THIS NOTICE

WE CAN CHANGE THE TERMS OF THIS NOTICE. AND THE CHANGES WILL APPLY TO ALL INFORMATION WE HAVE ABOUT YOU. THE NEW NOTICE WILL BE AVAILABLE UPON REQUEST. IN OUR OFFICE. AND ON OUR WEB SITE.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 772-335-4770.